

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

June 27, 2011

Dianne Heffron, Director
Financial Management Group
Center for Medicaid, CHIP and Survey & Certification
Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS-2328-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-2328-P Medicaid Program; Methods for Assuring Access to Covered Medicaid Services

Dear Ms. Heffron:

I am writing to you on behalf of Colorado's single state Medicaid agency, the Department of Health Care Policy and Financing to provide comment related to CMS-2328 P Medicaid Program; Methods for Assuring Access to Covered Medicaid Services proposed regulations under Section 1902(a)(30)(A) of the Social Security Act.

Colorado agrees that access to care is a vital aspect of its State Medicaid Program. Only through appropriate access to care will we achieve our State goals of improving health outcomes for our recipients and ensuring our purchase of health care is value-based. However, the proposed regulations raise areas of considerable concern for Colorado:

1. The placement of "assuring access to covered Medicaid services" provisions in 42 CFR Part 447 Subpart B Payment Methods: General Provisions appears to define access to care primarily as a function of payment rates and rate methodologies. This unwarranted presumption fails to recognize the complexities of provider participation decisions and Medicaid recipient care-seeking considerations. Colorado suggests CMS look to the Medicaid and CHIP Payment and Access Commission (MACPAC) initial report to Congress published March 2011 and the Chapter 4 discussion Examining Access to Care in Medicaid and CHIP. Neither the chapter nor its annex features such presumed primacy of payment rates and rate methodologies as drivers of access to care. This focus on payment rates and rate methodologies in the proposed regulations are not aligned with value-based purchasing initiatives that many States, including Colorado, are pursuing in their efforts to administer the Medicaid Program in keeping with the mandate for "economy, efficiency and appropriate utilization."

- 2. The proposed language is overbroad and ambiguous. If CMS' intent was to provide clarity and guidance, and to diminish potential vulnerabilities of States for litigation, Colorado perceives the proposed regulations as more likely to increase such potential vulnerability.
- 3. The proposed regulations threaten the integrity of the State/Federal partnership by limiting the ability of States to manage their Medicaid programs in accordance with requirements from both Congress and their State legislatures. Many States have a constitutional requirement to maintain a balanced budget. Restricting States' ability to reduce eligibility (via the Maintenance of Effort requirement) and restricting States' ability to contemplate incremental payment rate reductions and/or changes in rate methodology, may result in States being faced with the remaining drastic alternative of eliminating optional services.
- 4. The proposed regulations impose additional administrative burdens on States with a very questionable return on investment. Limited State staff and funding will be diverted from initiatives focused on transforming and modernizing Medicaid to better meet our recipients' needs, and will instead be spent performing cost studies to comply with the regulatory requirements as proposed. In addition, much of the data most responsive to questions of access might best be retrieved from provider practices. It is unclear whether the additional administrative burden to provide such data to the State would undermine or compromise existing levels of provider participation.
- 5. The proposed regulations do not consider the changing health care coverage environment resulting from enactment of the Affordable Care Act. It is unclear whether data developed and reported for comparison studies would yield information relevant to considerations of Medicaid payment rate reductions or whether such data might better reflect the background changes to the health care coverage landscape as a whole.
- 6. Colorado strongly recommends that CMS work closely with States in considering and then selecting either of two alternatives: a) Significantly reduce the scope of the proposed regulation to define a limited set of metrics that each State can easily generate through its claims processing data. b) Revise the proposed regulation to allow each State to assure that changes to payment rates and/or rate methodologies do not adversely affect access and submit a state plan amendment (SPA) for CMS review and approval that details the mechanism whereby the State will meet said assurance. Colorado has recent positive experience with this approach specific to Tribal Consultation requirements.

In addition to these overarching concerns, Colorado has specific comments on the proposed regulations as follows:

§447.203(b) Documentation of access to care and service payment rates Colorado notes that initial access reviews are unlikely to include "trends," which implies historical data that may not be available.

§447.203(b) Documentation of access to care and service payment rates Please clarify whether each State would be authorized to define its own geographic regions.

§447.203 (b)(1) Documentation of access to care and service payment rates. Please clarify the anticipated approach for reviewing access when a State adds any new service or benefit. Please also clarify the standards against which CMS will determine that the analysis demonstrates "sufficient" access.

§447.203 (b)(1)(iii) Documentation of access to care and service payment rates. Colorado believes that measuring utilization of covered services to determine appropriate access is in conflict with and ignores many States' efforts to ensure appropriate utilization.

§447.203 (b)(1)(iii)(B)Documentation of access to care and service payment rates. Please clarify CMS' expectation that the review must include all three proposed comparisons rather than at least one. The background narrative on page 26351 of the Federal Register published May 6, 2011 recognizes that most States set Medicaid rates based on one of the proposed structures. Colorado believes that requiring States to include the additional comparisons will drive more administrative work for little return in value.

§447.203(b)(1)(iii)(B)(1) Documentation of access to care and service payment rates. In Colorado's experience health care charges have virtually no relationship to the true cost of procuring services and are therefore not a valid reference for comparison.

§447.203(b)(1)(iii)(B)(3) Documentation of access to care and service payment rates. Please clarify CMS' expectations about including supplemental payments in the service payment rate comparisons. In Colorado's experience, supplemental payments are enhanced, lump sum payments made to specific provider groups that are not necessarily related to individual services provided to uniquely identified clients.

§447.203(b)(1)(iii)(C) Stratification requirement. Colorado disagrees that all provider payments should be broken down by state government-owned or operated, non-state government owned or operated, privately owned and operated. These categories are traditionally used for setting Upper Payment Limits, specifically for nursing facility, outpatient hospital and inpatient hospital services for which this information is readily available. It is not appropriate to expand the data analysis for all provider rates to be broken down by these categories and the information is not readily available.

447.203(b)(1)(iii)(D) Documentation of access to care and service payment rates. Please clarify CMS' expectations around State actions when the identified access issues have neither rate payment nor payment methodology solutions.

§447.203(b)(2)(i) Documentation of access to care and service payment rates. Please clarify CMS' intent around the January 1 annual reporting date. Colorado suggests that CMS further clarify the due dates so that there is consistency in covering 12 months of service, including payment run out to facilitate equitable comparisons across services or States. For example, all reporting date should be for a calendar year for services provided in the proceeding calendar year and published by the following June 1 each year to allow for claims processing and analysis.

§447.203 (b)(3)(ii) Documentation of access to care and service payment rates. Please clarify if the monitoring requirement applies to all payment methodology restructuring or only those that result in rate reductions.

§447.203 (b)(3)(ii) Documentation of access to care and service payment rates. Please clarify the standard against which CMS will measure if the State has demonstrated access, consistent with efficiency, economy, and quality of care.

§447.203 (b)(4) Documentation of access to care and service payment rates. Please clarify the intent of using only the word "beneficiary" input in this requirement when later requirements cite "stakeholder," which includes providers.

§447.204 (a) Medicaid provider participation and public process to inform access to care. Please clarify the standard against which CMS will measure that a State's payments are consistent with efficiency, economy, and quality of care.

§447.204(a)(2) Medicaid provider participation and public process to inform access to care. Please clarify the standard against which CMS will review input from beneficiaries and affected stakeholders. In Colorado's experience there is not always good correlation between the amount and level of input and the magnitude of proposed payment change.

§447.204(a)(2) Medicaid provider participation and public process to inform access to care. Colorado wishes to note the potential incentive created for stakeholder self-interest as a factor in prompting negative comments, even in cases of an appropriate level of payment rate reduction.

§447.204(b) Medicaid provider participation and public process to inform access to care. Colorado strongly recommends CMS eliminate the requirement that any proposed rate change SPA be accompanied by an analysis as described in §447.203 or face possible disapproval of the SPA. This requirement fails to recognize the timing realities associated with State budget decisions, and usurps State authority to make necessary program decisions.

§447.205(a) Public notice of changes in Statewide methods and standards for setting payment rates. Colorado suggests that CMS revise the requirement to: ether eliminate "significant" to recognize that all changes must be noticed or define significantly at a specified percent level. CMS guidance in the home and community-based services (HCBS) waiver programs has been that rate changes of less than 10 % do not require an amendment to the waiver. Colorado strongly suggests CMS be consistent in applying standards for payment rate changes to services provided under the authority of SPAs and waivers.

§447.205 (d)(2)(iv) Public notice of changes in Statewide methods and standards for setting payment rates. Colorado wishes to thank CMS for adding web site publication as an acceptable public notice method.

Thank you for the opportunity to provide comment on concerns and suggested changes to the proposed rules on methods to assure access to covered Medicaid services. Should you have any questions, I can be reached at Barbara.prehmus@state.co.us or via telephone at (303) 866-2991.

Sincerely,

Barbara B. Prehmus, M.P.H.

Federal Policy & Rules Officer

Cc: Ms. Susan E. Birch, MBA, BSN, RN, Executive Director

Ms. Lorez Meinhold, Deputy Policy Director, Governor's Office of Policy and Initiatives,

Colorado Governor John W. Hickenlooper

Ms. Cynthia Mann, Center for Medicaid, CHIP, Survey & Certification